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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE

FURTOSE AS OUTLINED IN 210 ILCS 43/3-208. DISCLOSORE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00434		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER				
	Address: Provena Geneva Care Center Address: 1101 E. State St. Number County: Kane	Geneva City	60134 Zip Code	State of and cert are true,	e examined the contents of the accompanying report to the Illinois, for the period from 1/1/03 to 12/31/03 tify to the best of my knowledge and belief that the said contents, accurate and complete statements in accordance with ole instructions. Declaration of preparer (other than provider)		
	Telephone Number: (630)232-7544 IDPA ID Number: 371127787005	Fax # ()		is based	on all information of which preparer has any knowledge. tional misrepresentation or falsification of any information ost report may be punishable by fine and/or imprisonment.		
	Date of Initial License for Current Owners:	03/01/98		Officer or	(Signed) (Date)		
	Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp.	PROPRIETARY Individual	GOVERNMENTAL State	of Provider	(Type or Print Name) Michael R Gordon (Title) Vice President		
	Trust IRS Exemption Code 501c3	Partnership Corporation	County Other		(Signed) (Date)		
		"Sub-S" Corp. Limited Liability Co. Trust		Preparer	(Print Name and Title)		
		Other		(Firm Name & Address) (Telephone) () Fax # ()			
	In the event there are further questions about this report, please contact: Name: Lynda Olinski Telephone Number: (708)478-7916				MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

STATE OF ILLINOIS Page 2

III. STATISTICAL DATA A. Licensure/curfictation level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds	Facility	Name & ID Numbe	er Provena Gen	eva Care Center			# 0043448 Report Period Beginning: 1/1/03 Ending: 12/31/03								
(must agree with license). Date of change in licensed beds 1 2 3 4 Beds at Beginning of Report Period Level of Care Report Period Level of Care Report Period Report Period Report Period Report Period Level of Care Report Period Report Per	III	I. STATISTICAI	L DATA					D. How many bed-hold days during this year were paid by Public Aid?							
1		A. Licensure/co	ertification level(s) of	f care; enter number	r of beds/bed days,			(Do not include bed-hold days in Section B.)							
1		(must agree v	with license). Date of	change in licensed b	eds		_								
Beds at Beginning of Licensure Beds at End of Report Period PyES NO X WES NO X Was the facility purchased or leased after January 1, 1978? YES X Date 3/1/1998 NO YES X Date 3/1/1998 NO YES NO X WES NO X								E. List all services provided by your facility for non-patients.							
Beds at Beginning of Licensure Beds at End of Report Period Report		1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)							
Reginning of Report Period Level of Care Report Period								N/A - Noe							
Report Period Level of Care Report Period Report Perio		Beds at				Licensed									
Skilled (SNF)	В	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes							
1	R	Report Period	Level of C	Care	Report Period	Report Period									
2 Skilled Pediatric (SNF/PED) 2 3 107 Intermediate (ICF) 107 39,055 3 4 5															
3															
H. Does the BALANCE SHEET (page 17) reflect any non-care assets? Sheltered Care (SC)				. ,				YES NO X							
Sheltered Care (SC)		107		` /	107	39,055									
CF/DD 16 or Less															
1								YES NO X							
Totals	6		ICF/DD 16 or Less					I. On what date did you start providing long term care at this location?							
B. Census-For the entire report period. 1 2 3 4 5 Level of Care Patient Days by Level of Care and Primary Source of Payment Public Aid Recipient Private Pay Other Total 8 SNF 21,029 7 12,466 10 11 ICF/DD 7 12,466 10 11 ICF/DD 7 12,466 10 11 ICF/DD 7 12,466 10 12 SC 12 DAYS THE Facility purchased or leased after January 1, 1978? YES X Date 3/1/1998 NO X If YES, enter number of beds certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided NO X If YES, enter number of beds certified and days of care provided NO X If YES, enter number of beds certified and days of care provided NO X If YES, enter number of beds certified and days of care provided NO X If YES, enter number of beds certified and days of care provided NO X If YES, enter number of beds certified and days of care provided NO X If YES, END YES NO X If YES, enter number of beds certified and days of care provided NO X If YES, END YES NO X If YES, enter number of beds certified and days of care provided NO X If YES, END YES NO X If YES, enter number of beds certified and days of care provided NO X If YES, END YES NO X If YES, enter number of beds certified and days of care provided NO X If YES, END YES NO X If YES, enter number of beds certified for Medicare during the reporting year? YES X Date 3/1/1998 NO X If YES, enter number of beds certified for Medicare during the reporting year? YES X Date 3/1/1998 NO X If YES, and YES NO X IS NO	7	7 107 TOTALS 107 39.055 7				7									
B. Census-For the entire report period. 1		107	1011125		101	25,000									
B. Census-For the entire report period. 1								J. Was the facility purchased or leased after January 1, 1978?							
Level of Care Patient Days by Level of Care and Primary Source of Payment Public Aid Recipient Private Pay Other Total 8 SNF 21,029		B. Census-For	the entire report per	iod.											
Public Aid Recipient Private Pay Other Total of beds certified and days of care provided		1	2	3	4	5									
Public Aid Recipient Private Pay Other Total of beds certified and days of care provided	L	evel of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?							
8 SNF 21,029 21,029 8 9 SNF/PED 9 Medicare Intermediary 10 ICF 12,466 10 11 ICF/DD 11 IV. ACCOUNTING BASIS 12 SC 12 13 DD 16 OR LESS 13 ACCRUAL X CASH*			Public Aid			,									
9 SNF/PED			Recipient	Private Pay	Other	Total		of beds certified and days of care provided							
10 ICF	8 SN	NF	21,029			21,029	8								
11 ICF/DD 11 IV. ACCOUNTING BASIS 12 SC 12 MODIFIED 13 DD 16 OR LESS 13 ACCRUAL X CASH*	9 SN	NF/PED					9	Medicare Intermediary							
12 SC				12,466		12,466									
13 DD 16 OR LESS 13 ACCRUAL X CASH* CASH* CASH*							-	IV. ACCOUNTING BASIS							
	-														
	13 DI	D 16 OR LESS					13	ACCRUAL X CASH* CASH*							
14 TOTALS 21,029 12,466 33,495 14 Is your fiscal year identical to your tax year? YES X NO	14 TO	OTALS	21,029	12,466		33,495	14	Is your fiscal year identical to your tax year? YES X NO							
C. Percent Occupancy. (Column 5, line 14 divided by total licensed Tax Year: 12/31/03 Fiscal Year: 12/31/03		C Percent Occ	ounancy (Column 5	line 14 divided by to	ntal licensed	Tay Vear: 12/31/03 Fiscal Vear: 12/31/03									
bed days on line 7, column 4.) 85.76% * All facilities other than governmental must report on the accrual basis.					rai neenseu										
		,			<u> </u>			A							

STATE OF II	LLI	NOIS				Page 3
	H	00/3//8	Danart Pariod Raginning	1/1/03	Ending	12/31/03

E III N A IDN I	D G		i	STATE OF ILI		D (D 1 1		1/1/03	E 11	Page 3	
Facility Name & ID Number	Provena Genev			#	0043448	Report Period	Beginning:	1/1/03	Ending:	12/31/03	_
V. COST CENTER EXPENSES (thro	ughout the report	t, please round t Costs Per Gener	to the nearest d	ollar)	Reclass-	Reclassified	Adjust-	Adjusted	EOD OHE	USE ONLY	_
On anoting Exmanses			-	Total	ification	Total	•		FOR OHE	USE UNLY	
Operating Expenses	Salary/Wage	Supplies	Other	Total			ments	Total		10	
A. General Services	1	2 7 7 7 0	3	4	5	6	7	8	9	10	
1 Dietary	195,615	3,559	16,646	215,820		215,820	2.025	215,820			1
2 Food Purchase		154,006		154,006		154,006	2,025	156,031			2
3 Housekeeping	75,808	6,390		82,198		82,198		82,198			3
4 Laundry	25,492	463	72,020	97,975		97,975	(9,770)	88,205			4
5 Heat and Other Utilities			70,288	70,288		70,288	4,856	75,144			5
6 Maintenance	41,113	5,578	33,551	80,242		80,242	699	80,941			6
7 Other (specify):* Pastoral Care/Devel	oj 67,927			67,927		67,927	(45,063)	22,864			7
8 TOTAL General Services	405,955	169,996	192,505	768,456		768,456	(47,253)	721,203			8
B. Health Care and Programs											
9 Medical Director		3,300		3,300		3,300		3,300			9
10 Nursing and Medical Records	1,669,320	13,545	3,661	1,686,526		1,686,526		1,686,526			10
10a Therapy											10a
11 Activities	107,257	1,486	312	109,055		109,055		109,055			11
12 Social Services											12
13 Nurse Aide Training											13
14 Program Transportation											14
15 Other (specify):*											15
16 TOTAL Health Care and Programs	1,776,577	18,331	3,973	1,798,881		1,798,881		1,798,881			16
C. General Administration											
17 Administrative	172,965	1,010	627,811	801,786		801,786	(352,033)	449,753			17
18 Directors Fees			•	·			, , , ,	•			18
19 Professional Services			83,084	83,084		83,084	13,631	96,715			19
20 Dues, Fees, Subscriptions & Promotions			18,101	18,101		18,101	(5,392)	12,709			20
21 Clerical & General Office Expenses		6,458	18,956	25,414		25,414	(4,730)	20,684			21
22 Employee Benefits & Payroll Taxes		,	505,960	505,960		505,960	46,323	552,283			22
23 Inservice Training & Education			5,737	5,737		5,737	7,264	13,001			23
24 Travel and Seminar			8,759	8,759		8,759	4,514	13,273			24
25 Other Admin. Staff Transportation			-,	-,		1	<i>)</i>	-,			25
26 Insurance-Prop.Liab.Malpractice			42,634	42,634		42,634		42,634			26
27 Other (specify):* Bad Debt			82,103	82,103		82,103	(82,103)	, -			27
28 TOTAL General Administration	172,965	7,468	1,393,145	1,573,578		1,573,578	(372,526)	1,201,052			28
TOTAL Operating Expense	Í	ĺ		, i				2.521.126			
29 (sum of lines 8, 16 & 28) *Attach a schedule if more than one ty	2,355,497	195,795	1,589,623	4,140,915		4,140,915	(419,779)	3,721,136		I .	29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

		Cost Per General Led		al Ledger	Ledger		Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	T
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			306,857	306,857		306,857	(61)	306,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							179,375	179,375			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,159	14,159			34
35	Rent-Equipment & Vehicles			14,962	14,962		14,962	1,161	16,123			35
36	Other (specify):*											36
37	TOTAL Ownership			321,819	321,819		321,819	194,634	516,453			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			66,372	66,372		66,372		66,372			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,583	58,583		58,583		58,583			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			124,955	124,955		124,955		124,955	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,355,497	195,795	2,036,397	4,587,689		4,587,689	(225,145)	4,362,544			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning:

1/1/03

Ending:

Page 5 12/31/03

4

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III COLUMN	1 2 below, reference the	ine on wi	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ar cost
		1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(374)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(9,770)	4		8
9	Non-Straightline Depreciation	(3,174)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(10,808)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
-	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,103)	27		24
25	Fund Raising, Advertising and Promotional	(11,739)	20		25
	Income Taxes and Illinois Personal				
	Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,968)		\$	30

	OHF USE ONLY									
48		49		50		51		52		

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	<u> </u>	
	Amount	Reference	
Non-Paid Workers-Attach Schedule*	\$		31
Donated Goods-Attach Schedule*			32
Amortization of Organization &			
Pre-Operating Expense			33
Adjustments for Related Organization			
Costs (Schedule VII)	(55,938)	Var	34
Other- Attach Schedule	(51,239)	Var	35
SUBTOTAL (B): (sum of lines 31-35)	\$ (107,177)		36
(sum of SUBTOTALS			
TOTAL ADJUSTMENTS (A) and (B))	\$ (225,145)		37
	Donated Goods-Attach Schedule* Amortization of Organization & Pre-Operating Expense Adjustments for Related Organization Costs (Schedule VII) Other- Attach Schedule SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	Non-Paid Workers-Attach Schedule* Donated Goods-Attach Schedule* Amortization of Organization & Pre-Operating Expense Adjustments for Related Organization Costs (Schedule VII) (55,938) Other- Attach Schedule (51,239) SUBTOTAL (B): (sum of lines 31-35) \$ (107,177)	Non-Paid Workers-Attach Schedule* Donated Goods-Attach Schedule* Amortization of Organization & Pre-Operating Expense Adjustments for Related Organization Costs (Schedule VII) (55,938) Var Other- Attach Schedule (51,239) Var SUBTOTAL (B): (sum of lines 31-35) \$ (107,177) (sum of SUBTOTALS

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

4	,					
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Page 5A

Provena Geneva Care Center

ID#	0043448
Report Period Beginning:	1/1/03
Ending:	12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference
velopment - Salaries	\$ (45,063)	7

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Development - Salaries	\$ (45,063)	7	1
2	Development - Misc. Net Asset Released	(1,879)	17	2
3	Development - Events	2	17	3
4	Development - Supplies, Publications	(94)	21	4
5	Development - Dues/Books	(62)	20	5
6	Development - Benefits	(3,487)	22	6
7	Development - Food	(36)	2	7
8	Development - Travel	(620)	24	8
9	•	` ′		9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				_
23				22
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24				24
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51,239)		49
	* **	(= :,=00)		

Summary A # 0043448 Report Period Beginning: 1/1/03 Ending: 12/31/03

Facility Name & ID Number Provena Geneva Care Center
SUMMARY OF PAGES 5. 5A, 6. 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

	SUMMARY OF PAGES 5, 5A, 6, 6A	1, 6B, 6C, 6D, 0	6E, 6F, 6G, 6H	I AND 61										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	•	1
2	Food Purchase	(410)	2,435	0	0	0	0	0	0	0	0	0	2,025	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0		3
4	Laundry	(9,770)	0	0	0	0	0	0	0	0	0	0	(9,770)	4
5	Heat and Other Utilities	0	4,856	0	0	0	0	0	0	0	0	0	,	5
6	Maintenance	0	699	0	0	0	0	0	0	0	0	0	699	6
7	Other (specify):*	(45,063)	0	0	0	0	0	0	0	0	0	0	(45,063)	7
8	TOTAL General Services	(55,243)	7,990	0	0	0	0	0	0	0	0	0	(47,253)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,877)	(350,156)	0	0	0	0	0	0	0	0	0	(352,033)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,631	0	0	0	0	0	0	0	0	0	13,631	19
20	Fees, Subscriptions & Promotions	(11,801)	6,409	0	0	0	0	0	0	0	0	0	(5,392)	20
21	Clerical & General Office Expenses	(10,902)	6,172	0	0	0	0	0	0	0	0	0	(4,730)	21
22	Employee Benefits & Payroll Taxes	(3,487)	49,810	0	0	0	0	0	0	0	0	0	46,323	22
23	Inservice Training & Education	0	7,264	0	0	0	0	0	0	0	0	0	7,264	23
24	Travel and Seminar	(620)	5,134	0	0	0	0	0	0	0	0	0	4,514	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(82,103)	0	0	0	0	0	0	0	0	0	0	(82,103)	27
28	TOTAL General Administration	(110,790)	(261,736)	0	0	0	0	0	0	0	0	0	(372,526)	28
	TOTAL Operating Expense	_							_					
29	(sum of lines 8,16 & 28)	(166,033)	(253,746)	0	0	0	0	0	0	0	0	0	(419,779)	29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
30	Depreciation	(3,174)	0	3,113	0	0	0	0	0	0	0	0	(61)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	179,375	0	0	0	0	0	0	0	0	179,375	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,159	0	0	0	0	0	0	0	0	14,159	34
35	Rent-Equipment & Vehicles	0	0	1,161	0	0	0	0	0	0	0	0	1,161	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,174)	0	197,808	0	0	0	0	0	0	0	0	194,634	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(169,207)	(253,746)	197,808	0	0	0	0	0	0	0	0	(225,145)	45

0043448

Page 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Litter below the hames of ALL	owners and re	iatea organiz	ations (parties) as actifica in	ine monactions	J. Attaon t	an additional se	neadle ii neec	Joury.		
1			2				3			
OWNERS		RELATED NURSING HOR	MES		OTHER	RELATED BUSIN	ESS ENTITI	IES		
Name	Ownership %	Name		City		Name	City		Type of Business	
		See Attached		1000		See Attached				
			·							

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-		· ·	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	2	Food Purchase	\$	Provena Senior Services	100.00%	\$ 2,435	\$ 2,435	1
2	V	3	Housekeeping - Supplies		Provena Senior Services	100.00%	0		2
3	V	5	Heat & Other Utilities		Provena Senior Services	100.00%	4,856	4,856	3
4	V	6	Maintenance - Other		Provena Senior Services	100.00%	699	699	4
5	V	17	Admin Salary Other Admin		Provena Senior Services	100.00%	166,452	166,452	5
6	V	17	Admin - Other	546,326	Provena Senior Services	100.00%	29,718	(516,608)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	13,631	13,631	7
8	V	20	Dues, Fees, Subs & Promotions		Provena Senior Services	100.00%	6,409	6,409	8
9	V	21	Clerical/Genl Supplies		Provena Senior Services	100.00%	4,080	4,080	9
10	V	21	Clerical/Gen - Other		Provena Senior Services	100.00%	2,092	2,092	10
11	V	22	Emp Benefits & Payroll Taxes		Provena Senior Services	100.00%	49,810	49,810	11
12	V	23	Inservice Training & Education		Provena Senior Services	100.00%	7,264	7,264	12
13	V	24	Travel & Seminar		Provena Senior Services	100.00%	5,134	5,134	13
14	Total			\$ 546,326			\$ 292,580	§ * (253,746)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOI	S				Page 6A
#	0043448	Report Period Beginning:	1/1/03	Ending:	12/31/03

VII.	REL	ATED	PARTIES	(continued)
------	-----	------	---------	-------------

Facility Name & ID Number

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

Provena Geneva Care Center

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					Name of Related Organization		Operating Cost	Adjustments for	
Scho	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	30	Depreciation	\$	Provena Senior Services	100.00%	\$ 3,113		15
16	V	32	Interest		Provena Senior Services	100.00%	179,375	179,375	16
17	V	34	Rent - Facility & Grounds		Provena Senior Services	100.00%	14,159	14,159	17
18	V	35	Rent - Equipment & Vehicles		Provena Senior Services	100.00%	1,161	1,161	18
19	V	17	Admin - Other	74,905	Provena Health	100.00%	74,905		19
20	V	19	Professional Services	52,888	Provena Health	100.00%	52,888		20
21	V	39	Ancillary Service Centers - Other	66,372	Provena Senior Services Pharmacy	100.00%	66,372		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			s 194,165			s 391,973	s * 197,808	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Provena Geneva Care Center

0043448

Report Period Beginning:

1/1/03

Ending:

12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation		oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs for this		Line &	
				Ownership	From Other	Work Week		Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	s		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization **Provena Senior Services** A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X

B. Show the allocation of costs below. If necessary, please attach worksheets.

Street Address	19065 Hickory Creek Drive, Ste 310
City / State / Zip Code	Mokena, IL60448
Phone Number	(708)478-7900
Fax Number	(708)478-5387

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	2	Food Purchase	Mgmt Fee Income	5,373,327	16	\$ 23,945	\$	546,326	\$ 2,435	1
2	3	Housekeeping - Supplies	Mgmt Fee Income	5,373,327	16	(3)		546,326	0	2
3	5	Heat & Other Utilities	Mgmt Fee Income	5,373,327	16	47,756		546,326	4,856	3
4	6	Maintenance - Other	Mgmt Fee Income	5,373,327	16	6,877		546,326	699	4
5	17	Admin Salary Other Admin	Mgmt Fee Income	5,373,327	16	1,637,117	1,637,117	546,326	166,452	5
6	17	Admin - Other	Mgmt Fee Income	5,373,327	16	292,291		546,326	29,718	6
7	19	Professional Services	Mgmt Fee Income	5,373,327	16	134,066		546,326	13,631	7
8	20	Dues, Fees, Subs & Promotions	Mgmt Fee Income	5,373,327	16	63,031		546,326	6,409	8
9	21	Clerical/Genl Supplies	Mgmt Fee Income	5,373,327	16	40,128		546,326	4,080	9
10	21	Clerical/Gen - Other	Mgmt Fee Income	5,373,327	16	20,574		546,326	2,092	10
11	22	Emp Benefits & Payroll Taxes	Mgmt Fee Income	5,373,327	16	489,898		546,326	49,810	11
12	23	Inservice Training & Education	Mgmt Fee Income	5,373,327	16	71,446		546,326	7,264	12
13	24	Travel & Seminar	Mgmt Fee Income	5,373,327	16	50,497		546,326	5,134	13
14	30	Depreciation	Mgmt Fee Income	5,373,327	16	30,618		546,326	3,113	14
15	32	Interest	Mgmt Fee Income	5,373,327	16	1,764,218		546,326	179,375	15
16	34	Rent - Facility & Grounds	Mgmt Fee Income	5,373,327	16	139,255		546,326	14,159	16
17	35	Rent - Equipment & Vehicles	Mgmt Fee Income	5,373,327	16	11,422		546,326	1,161	17
18										18
19										19
20										20
21	•							_		21
22										22
23										23
24										24
25	TOTALS					\$ 4,823,136	\$ 1,637,117		\$ 490,388	25

Page 8	3 A	١
Pag	ge 8	ge 8 <i>A</i>

1/1/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS		
	Name of Related Organization	Provena Health Services
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	9223 West St. Francis Road
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Frankfurt, IL 60423
, — · · · · · · · · · · · · · · · · · ·	Phone Number	(815)469-4888
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	815)469-4864

0043448 Report Period Beginning:

Facility Name & ID Number

Provena Geneva Care Center

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	Admin - Other	Direct Allocation			\$	\$		\$ 74,905	1
2	19	Professional Services	Direct Allocation						52,888	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 127,793	25

STATE OF ILLINOIS	Page 8B
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Facility Name & ID Number Provena Geneva Care Center	#	0043448	Report Period Beginning:	1/1/03	Ending:	12/31/03
VIII. ALLOCATION OF INDIRECT COSTS						
			Name of Related	Organization	Provena Seni	or Services Pharmacy
A. Are there any costs included in this report which were derived from allocations of centra	26	Street Address	_	1475 Harvar	d Drive	
or parent organization costs? (See instructions.) YES NO			City / State / Zip	Code	Kankakee, II	60901
			Phone Number		(815)928-6	141
B. Show the allocation of costs below. If necessary, please attach worksheets.		Fax Number		(815)946-3	3238	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			\$	\$		\$ 66,372	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					S	\$		\$ 66,372	25

Faci	ility Name & ID Number	Provena (Geneva Care Center	#	STATE OI # 0043448	FILLINOIS Report Period	Beginning:	1/1/03	Ending:	Page 9 12/31/03	
	IX. INTEREST EXPENSE AN	DDEALE	OTATE TAV EVDENCE			•	0 0				
					·c	`					
	A. Interest: (Complete deta	iis must be	provided for each loan - attach a se	eparate schedule			-	0	0	10	
	I		3	4	5	6	7	8	9	10	_
										Reporting	
				Monthly				Maturity	Interest	Period	
	Name of Lender	Related*		Payment	Date of		unt of Note	Date	Rate	Interest	
		YES N	0	Required	Note	Original	Balance		(4 Digits)	Expense	Щ
	A. Directly Facility Related										
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6	9 1										6
7											7
8											8
											Ť
9	TOTAL Facility Related					\$	\$			•	9
	B. Non-Facility Related*				I	Ψ	Ψ	_		Ψ	Ł
10	Provena Senior Services				T			T T	Т	179,375	10
11								-		117,513	11
12					+						12
13				1	1						13
13									_		13
14	TOTAL Non-Facility Related					\$	\$			\$ 179,375	14

179,375

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ 	Line #

15 TOTALS (line 9+line14)

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

B. Real Estate Taxes								
1. Peal Estate Tay against yeard on 2002 concept	<i>Important</i> , please see the next worksheet, "bill must accompany the cost report.	RE_Tax". The rea	estate tax statement and	s				
1. Real Estate Tax accrual used on 2002 report.	Siii maat accompany the coet report.			3	1			
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment cover	rs more than one year,	detail below.)	\$	2			
3. Under or (over) accrual (line 2 minus line 1).				s	3			
4. Real Estate Tax accrual used for 2003 report. (Detail	and explain your calculation of this accrual on the lines	below.)		s	4			
5. Direct costs of an appeal of tax assessments which he (Describe appeal cost below. Attach copies)	s	5						
	6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.							
7. Real Estate Tax expense reported on Schedule V, lin	233. This should be a combination of lines 3 thru 6.			\$	7			
Real Estate Tax History:								
Real Estate Tax Bill for Calendar Year: 1998	8		FOR OHF USE ONLY					
1995 2000	9 10	13	FROM R. E. TAX STATEMENT FO	OR 2002 \$	13			
2001 2002	11 12	14	PLUS APPEAL COST FROM LINE	5 \$	14			
		15	LESS REFUND FROM LINE 6	\$	15			
		16	AMOUNT TO USE FOR RATE CA	LCULATION\$	16			

NOTES:

- ${\bf 1.} \ \ {\bf Please\ indicate\ a\ negative\ number\ by\ use\ of\ brackets(\).\ \ Deduct\ any\ over accrual\ of\ taxes\ from\ prior\ year.$
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

ACI	ILITY NAME Provena Ger	neva Care Center	COUNTY	Kane
ACI	ILITY IDPH LICENSE NUMB	ER 0043448		
ON	TACT PERSON REGARDING	THIS REPORT		
ELE	EPHONE ()	FAX#	: ()	
۱	Summary of Real Estate Tax			
	Enter the tax index number and cost that applies to the operation home property which is vacant	d real estate tax assessed for 2002 on on of the nursing home in Column D. , rented to other organizations, or use include cost for any period other than	Real estate tax applicable d for purposes other than	e to any portion of the nursir
	(A)	(B)	(C)	(D)
1. 2. 3. 4. 5. 6. 7.	Tax Index Number		\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$
8. 9			_	
10.			_	_ <u> </u>
3	D. I.F. (T. C. (All.)	TOTAL	s	
٥.	Real Estate Tax Cost Allocat			
	Does any portion of the tax bil used for nursing home services	l apply to more than one nursing hom		perty which is not direct
		& a schedule which shows the calcula ost must be allocated to the nursing h		

C. <u>Tax Bills</u>

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

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Facili	ty Name & ID Number Provena Ge	eneva Care Center		STATE OF	FILLINOIS 0043448	S Report Period Begin	ning:	1/1/03	Ending:	Page 11 12/31/03
	ILDING AND GENERAL INFOR			_			- B'		. 8	
A.	Square Feet: 36,0	00 B. General Construction Type:	Exterior	Brick		Frame		Number of St	ories	1994
C.	Does the Operating Entity?	x (a) Own the Facility	(b) Rent from	a Related O	rganizatior	1.		(c) Rent from Con Organization.	mpletely Unr	elated
	(Facilities checking (a) or (b) must	complete Schedule XI. Those checking (c)) may complete Schedu	ıle XI or Sch	edule XII-	A. See instructions.				
D.	Does the Operating Entity?	x (a) Own the Equipment	(b) Rent equip	oment from a	Related O	organization.	X	(c) Rent equipme Unrelated Org		pletely
	(Facilities checking (a) or (b) must	complete Schedule XI-C. Those checking	(c) may complete Scho	edule XI-C o	r Schedule	XII-B. See instruction	s.		,	
E.	List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable) None									

STATE OF ILLINOIS

YES

2. Number of Years Over Which it is Being Amortized:

x NO

XI. OWNERSHIP COSTS:

1. Total Amount Incurred:

3. Current Period Amortization:

If so, please complete the following:

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

Nature of Costs:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

4. Dates Incurred:

Page 12 12/31/03 Facility Name & ID Number Provena Geneva Care Center # 0043

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar # 0043448 Report Period Beginning: 1/1/03 Ending:

	1	ng Depreciation-Including Fixed Equip FOR OHF USE ONLY	2 Year	3 Year		4	C	5 urrent Book	6 Life in Years	7 Straight Line	8	9 nulated	T
	Beds*		Acquired	Constructed		Cost	D	epreciation		Depreciation	Adjustments	eciation	
4	107		1998		8	5,000,000	\$	166,667	30	\$ 166,667	2	\$ 916,667	4
5													5
6													6
7													7
8													8
	Impro	ovement Type**											
9	Various			1999		23,662		2,816	10	2,816		13,630	9
10													10
11		VIA PAINTING		2000		536		107	5	107		375	11
12	DESC: GCC	COMMON AREA ASSESSMENT		2000		2,743		549	5	549		1,920	12
13	DESC: PAIN	Γ DOOR FRAMES & WALLS		2000		3,646		729	5	729		2,552	13
14	DESC: RGB	MAJOR BUILDING CONSULTING		2000		5,712		571	10	571		1,999	14
15	DESC: RGB	ARCHITECTURAL SERVICES		2000		255		43	3	43		255	15
16	DESC: RGB	ARCHITECTURAL SERVICES		2001		633		127	5	127		317	16
17	DESC: CODE	E ALERT (ALZHEIMER'S UNIT)		2001		16,637		1,664	10	1,664		4,159	17
18	DESC: INSTA	ALLATION - NEIFLOOR MATERIAL		2001		98,158		6,544	15	6,544		16,267	18
19	DESC: BUIL	DING ADDITION		2001		523,508		17,450	30	17,450		44,632	19
20	DESC: PLUM	IBING - PIPE REPLACEMENT		2002		544		22	25	22		33	20
21	DESC: CARP	PETING		2002		824		165	5	165		165	21
22	DESC: MURA	AL FOR VISTA AREA		2002		4,500		643	7	643		643	22
23	DESC: MURA	ALS IN VISTA UNIT		2002		2,250		450	5	450		675	23
24	DESC: KJWV	W ENGINEERING CONSULTANT		2003		1,767		177	5	177		177	24
25	DESC: CARP	PETING		2003		824		27	15	27		27	25
26	DESC: CORN	NICE		2003		785		79	5	79		79	26
27		ACEMENT OF GAS AIR MAKE-UP UNI	Γ	2003		15,843		528	15	528		528	27
28	DESC: CORN	NER CORNICE		2003		595		60	5	60		60	28
29	DESC: PARK	ING LOT RENOVATION		2003		8,115		406	10	406		406	29
30	DESC: FIRE	DAMPERS		2003		7,452		248	15	248		248	30
31		SCAPING FOR 1/3 OF COURTYARD		2003		2,575		129	10	129		129	31
32	DESC: WAST	TE DRAINS		2003		14,952		748	10	748		748	32
33	DESC: BACK	FLOW PREVENTER FOR SPRINKLER	SYS	2003		6,850		343	10	343		343	33
34	DESC: OUTS	IDE PORCH AREA SPRINKLER		2003		7,900		395	10	395		395	34
35	DESC: VENT	AND EJECTOR SYSTEM FOR KITCHE	N	2003		3,506		175	10	175		175	35
36	DESC: KITO	CHEN TILE		2003		3,053		102	15	102		102	36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Provena Geneva Care Center # 00

XI. OWNERSHIP COSTS (continued)

R. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	B. Building Depreciation-Including Fixed Equipment. (See instr	ructions.) Rour	id all numbers to near	rest dollar					
	1	3	4	5	6	7	8	9	
		Year		Current Book	Life	Straight Line Depreciation		Accumulated	
	Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64 65
65									
66									66
67									67
68 69									68
	TOTAL (lines 4 thun 60)		e 5 757 935	6 201.061		0 201.061	6	e 1.007.702	69
/0	TOTAL (lines 4 thru 69)		\$ 5,757,825	\$ 201,961		\$ 201,961	\$	\$ 1,007,703	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete

STATE	OFI	III	MIC

Page 13 # 0043448 1/1/03 12/31/03 Facility Name & ID Number Provena Geneva Care Center **Report Period Beginning: Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 914,157	\$ 100,111	\$ 100,111	\$	10	\$ 511,055	71
72	Current Year Purchases	96,717	4,725	4,725		10	4,725	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,010,875	\$ 104,836	\$ 104,836	\$		\$ 515,779	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

	E. Summary of Care-Related Assets	1	2			
		Reference	Amount			i
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,768,	700	81	i
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,	796	82	ł
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 306,	796	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84	i
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,523,	483	85	i

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	İ
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

^{**} This must agree with Schedule V line 30, column 8.

STA	TE OF ILLINOIS
#	0043448

						STA	TE OF ILLINOIS	\$						Page 14
Faci	lity Name & I	D Number	Provena Genev	a Care Center		#	0043448		Report I	Period B	eginning:	1/1/03	Ending:	12/31/03
XII.	1. Name of 2. Does the	and Fixed Equ Party Holding	y real estate taxes in	,	al amount shown below or	n line	7, column 4? YES X]NO						
		1	2	3	4		5		6					
		Year	Number	Date of	Rental		Total Years		l Years					
		Constructe	ed of Beds	Lease	Amount		of Lease	Renewa	l Option*		40 700			
,	Original				e e					,	10. Effective d		it rental agree	ment:
4	Building: Additions			-	3	-				3	Beginning _ Ending			
5	Allocation - 1	Home Office			14,159	_				5	Enumg _			
6	- Inocucion				1,,10	-				6	11. Rent to be	paid in future	e vears under	the current
7	TOTAL				\$ 14,159	-				7	rental agre	-	,	
	This amo		ortization of lease ex lated by dividing the se								Fiscal Year 12. 13.	/2004 /2005	Annual R \$	ent
	9. Option to	Buy:	YES	X NO	Terms:		*				14.	/2006	\$	
	15. Îs Mova 16. Rental A	ble equipment Amount for mo	ransportation and F trental included in b ovable equipment:	ouilding rental?	. (See instructions.) Description:	Nurs	sing \$10,851, Activ	NO rities \$486, le detailing	Dietary \$1	,470, Pla lown of	nt Eng \$1,039, La movable equipme	undry \$696, <i>2</i> nt)	Admin \$420, F	Iome Office\$1
	C. Vehicle R	ental (See inst	ructions.)		3	ı	4		_					
	1		Model Year		Monthly Lease		Rental Expense							
	Use		and Make		Payment		for this Period				* If there i	s an option to	buy the build	ing,
	N/A			\$		\$		1					te details on a	ttached
18						<u> </u>		13			schedule	•		
19 20						 		2			** This	aunt alus s	amortization	of loose
	TOTAL	-		6		e.		2						
21	IOIAL			5		\$			L		<u>expense</u> 1	must agree wi	ith page 4, line	34.

	Name & ID Number Provena Geneva Car				#	0043448	Report Period Beginning:	1/1/03	Ending:	12/31/03
XIII. EX	PENSES RELATING TO NURSE AIDE TRAINING	G PROGRAMS (See i	nstructions.)							
A. '	TYPE OF TRAINING PROGRAM (If aides are train	ned in another facility	program, attach a	schedule listing t	he facility	name, addre	ss and cost per aide trained in t	hat facility.)		
	1. HAVE YOU TRAINED AIDES	YES 2	. CLASSROOM	PORTION:			3. CLINICAL PO	DTION.		
	DURING THIS REPORT	ILS 2	. CLASSICOM	TORTION			3. <u>CERTIFICATIO</u>	KIION.	_	
	PERIOD?	X NO	IN-HOUSE PR	OGRAM			IN-HOUSE PR	OGRAM		
		<u> </u>								
			IN OTHER FA	CILITY			IN OTHER FA	CILITY		
	If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY	COLLECE			HOURS PER A	IDF		
	explanation as to why this training was		COMMONITI	COLLEGE			HOURSTER	IIDE		
	not necessary.		HOURS PER A	AIDE						
	•									
В. І	EXPENSES	ALLOCAT	ION OF COSTS	(d)			C. CONTRACTUAL IN		amount of in	come your
		1	2	3		4	facility received	l training aid	es from other	r facilities.
			ncility						_	
		Drop-outs	Completed	Contract		Total	\$			
1	Community College Tuition	\$	\$	\$	\$					
	Books and Supplies						D. NUMBER OF AIDE	S TRAINED		
3	Classroom Wages (a)									
4	Clinical Wages (b)						COMPLET			
5	In-House Trainer Wages (c)						1. From this fac			
6	Transportation						2. From other f			
7	Contractual Payments						DROP-OU	TS		
8	Nurse Aide Competency Tests						1. From this fac	cility		
9	TOTALS	\$	\$	\$	\$		2. From other f	acilities (f)		

STATE OF ILLINOIS

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Provena Geneva Care Center

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	, , ,	1	2	3	4	5	6	7	8	
		Schedule V	Staf	i	Outside	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	an consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts				66,372		66,372	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 66,372		\$ 66,372	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

(last day of reporting year)

As of 12/31/03

		1		2 After	
		_	Operating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	8,794,696	\$	1
2	Cash-Patient Deposits		77,816		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		10,376,541		3
4	Supply Inventory (priced at)		485,379		4
5	Short-Term Investments				5
6	Prepaid Insurance		19,788		6
7	Other Prepaid Expenses		803,877		7
8	Accounts Receivable (owners or related parties)		251,746		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	20,809,843	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments		7,263,715		12
13	Land		6,877,199		13
14	Buildings, at Historical Cost		72,927,547		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		13,543,467		16
17	Accumulated Depreciation (book methods)		(39,708,360)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds		38,281		21
22	Other Long-Term Assets (specify):				22
23	Other(specify): Goodwill		147,576		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	61,089,425	\$	24
	TOTAL ACCETS				
1 25	TOTAL ASSETS		01 000 270	Φ.	25
25	(sum of lines 10 and 24)	\$	81,899,268	\$	25

		1	O perating	2 After Consolidation*	
26	C. Current Liabilities Accounts Payable	S	1,893,009	s	26
27	Officer's Accounts Payable	Э	1,893,009	3	27
28	3		1 021 666		28
29	Accounts Payable-Patient Deposits		1,831,666		
	Short-Term Notes Payable		1,152,937		29
30	Accrued Salaries Payable		2,954,499		30
2.1	Accrued Taxes Payable				2.1
31	(excluding real estate taxes)		100.166		31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,166		32
33	Accrued Interest Payable		320,867		33
34	Deferred Compensation		24,581		34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Due to Related Party		50,095		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	8,350,820	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		41,981,938		39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation		102,004		42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	42,083,942	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	50,434,762	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	31,464,506	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	Y \$	81,899,268	\$	48

^{*(}See instructions.)

IANGES IN EQUITY			
		1 Total	
Balance at Beginning of Year, as Previously Reported	s		1
Restatements (describe):	1		2
2002 Goodwill Write off per Audit		(3,481,389)	3
Adj. To Reconcile Consolidated Equity and Consolidated			4
Net Income to Nursing Facility Amounts		2,026,896	5
Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	31,930,099	6
A. Additions (deductions):			
NET Income (Loss) (from page 19, line 43)		(465,593)	7
Aquisitions of Pooled Companies			8
Proceeds from Sale of Stock			9
Stock Options Exercised			10
Contributions and Grants			11
Expenditures for Specific Purposes			12
Dividends Paid or Other Distributions to Owners	()	13
Donated Property, Plant, and Equipment			14
Other (describe)			15
Other (describe)			16
TOTAL Additions (deductions) (sum of lines 7-16)	\$	(465,593)	17
B. Transfers (Itemize):			
			18
			19
			20
			21
		<u> </u>	22
TOTAL Transfers (sum of lines 18-22)	\$		23
BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	31,464,506	24
	Balance at Beginning of Year, as Previously Reported Restatements (describe): 2002 Goodwill Write off per Audit Adj. To Reconcile Consolidated Equity and Consolidated Net Income to Nursing Facility Amounts Balance at Beginning of Year, as Restated (sum of lines 1-5) A. Additions (deductions): NET Income (Loss) (from page 19, line 43) Aquisitions of Pooled Companies Proceeds from Sale of Stock Stock Options Exercised Contributions and Grants Expenditures for Specific Purposes Dividends Paid or Other Distributions to Owners Donated Property, Plant, and Equipment Other (describe) Other (describe) TOTAL Additions (deductions) (sum of lines 7-16) B. Transfers (Itemize):	Balance at Beginning of Year, as Previously Reported Restatements (describe): 2002 Goodwill Write off per Audit Adj. To Reconcile Consolidated Equity and Consolidated Net Income to Nursing Facility Amounts Balance at Beginning of Year, as Restated (sum of lines 1-5) A. Additions (deductions): NET Income (Loss) (from page 19, line 43) Aquisitions of Pooled Companies Proceeds from Sale of Stock Stock Options Exercised Contributions and Grants Expenditures for Specific Purposes Dividends Paid or Other Distributions to Owners (Donated Property, Plant, and Equipment Other (describe) Other (describe) TOTAL Additions (deductions) (sum of lines 7-16) B. Transfers (Itemize): TOTAL Transfers (sum of lines 18-22)	Balance at Beginning of Year, as Previously Reported Restatements (describe): 2002 Goodwill Write off per Audit Adj. To Reconcile Consolidated Equity and Consolidated Net Income to Nursing Facility Amounts Balance at Beginning of Year, as Restated (sum of lines 1-5) A. Additions (deductions): NET Income (Loss) (from page 19, line 43) Aquisitions of Pooled Companies Proceeds from Sale of Stock Stock Options Exercised Contributions and Grants Expenditures for Specific Purposes Dividends Paid or Other Distributions to Owners Other (describe) Other (describe) TOTAL Additions (deductions) (sum of lines 7-16) S (465,593) TOTAL Transfers (Itemize):

^{*} This must agree with page 17, line 47.

Report Period Beginning:

1/1/03

Ending:

Page 19 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

			1	
	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	4,062,301	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	4,062,301	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care		3,780	13
14	Non-Patient Meals		374	14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs		28,353	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry		9,770	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	42,277	23
	D. Non-Operating Revenue			
24	Contributions		5,296	24
25	Interest and Other Investment Income***			25
26		\$	5,296	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
	Purchase Discounts		10,808	28
	Misc Income - Transportation		1,414	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	12,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	4,122,096	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		768,456	31
32	Health Care		1,798,881	32
33	General Administration		1,573,578	33
	B. Capital Expense			
34	Ownership		321,819	34
	C. Ancillary Expense			
35	Special Cost Centers		66,372	35
36	Provider Participation Fee		58,583	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	4,587,689	40
41	Income before Income Taxes (line 30 minus line 40)**		(465,593)	41
	- m			
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	e	(465,593)	43
43	NET INCOME OR LOSS FOR THE TEAR (line 41 linius line 42)	Φ	(403,393)	43

*	This must	agree with 1	page 4, li	ne 45,	column 4.
---	-----------	--------------	------------	--------	-----------

^{**} Does this agree with taxable income (loss) per Federal Income
Tax Return? Yes If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Provena Geneva Care Center

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(This senedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,888	2,080	\$ 66,787	\$ 32.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,231	23,229	583,327	25.11	3
4	Licensed Practical Nurses	6,969	7,496	160,888	21.46	4
5	Nurse Aides & Orderlies	57,591	61,380	811,378	13.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,062	3,280	46,940	14.31	8
9	Activity Director	1,876	2,080	25,341	12.18	9
10	Activity Assistants	8,899	9,446	81,916	8.67	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,756	2,054	37,807	18.41	13
14	Head Cook	7,479	8,181	80,999	9.90	14
15	Cook Helpers/Assistants	10,283	10,962	76,809	7.01	15
16	Dishwashers					16
17	Maintenance Workers	1,844	2,080	41,113	19.77	17
	Housekeepers	8,029	8,631	75,808	8.78	18
19	Laundry	2,034	2,218	25,492	11.49	19
20	Administrator	1,820	2,080	63,081	30.33	20
21	Assistant Administrator					21
22	Other Administrative	4,046	4,369	63,802	14.60	22
23	Office Manager					23
24	Clerical	4,276	4,493	46,082	10.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	3,780	4,100	67,927	16.57	33
34	TOTAL (lines 1 - 33)	146,863	158,159	s 2,355,497 *	s 14.89	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	132	\$ 9,773		35
36	Medical Director	\$275/mth	3,300		36
37	Medical Records Consultant	21	1,053		37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,985		44
45	Social Service Consultant	11	633		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	199	s 16,744		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

^{**} See instructions.

STATE OF ILLINOIS	3		Page	e 21
# 0042449	Donaut Davied Deginnings	1/1/02	Endings	12/21/02

Facility Name & ID Number	Provena Geneva Ca	are Center			#_0043	448	Repo	ort Period Begi	nning:	1/1/03	Ending:	12/31/03
XIX. SUPPORT SCHEDULES												
A. Administrative Salaries		Ownership			D. Employee Benefits and I					es, Subscriptions and	l Promotions	
Name	Function	%		Amount	Descri			Amount		Description		Amount
Janelle Chadwick	Administrator		\$_	63,081	Workers' Compensation In		_ \$_	39,563	IDPH Licer		\$	
Other	Other Admin		_	109,884	Unemployment Compensat	ion Insurance	_	13,347		g: Employee Recruitr		
			_		FICA Taxes		_	166,292		e Worker Backgroui		
			_		Employee Health Insurance	,	_	129,958	(Indicate #	of checks performed	<u>36</u>)	
	_		_		Employee Meals		_	0				
			_		Illinois Municipal Retireme	nt Fund (IMRF)*	_	0				
			_		Other Benefits		_	153,313	Dues & Sub			18,101
TOTAL (agree to Schedule V, lir							_		Advertising	and Public Relations	<u>s</u>	
(List each licensed administrator	· separately.)		\$_	172,965			_					
B. Administrative - Other					Home Office Allocation		_	49,810		e Allocation		6,409
									Less: Pub	lic Relations Expense	e (
Description				Amount					Non-	allowable advertising	g	(11,739)
Corp Service Fee			\$	74,905					Yello	ow page advertising	(
Mgmt Fee				239,288								
Mgmt Fee Interest			_	307,038	TOTAL (agree to Schedule	· V,	\$	552,283		TOTAL (agree to So	ch. V, \$	12,771
Miscellaneous			_	6,580	line 22, col.8)		_			line 20, col.	8)	
TOTAL (agree to Schedule V, lir	ne 17, col. 3)		\$	627,811	E. Schedule of Non-Cash C	ompensation Paid			G. Schedule	e of Travel and Semi	nar**	
(Attach a copy of any manageme	nt service agreemen	t)	_		to Owners or Employees							
C. Professional Services	-				7					Description		Amount
Vendor/Payee	Type			Amount	Description	Line #		Amount		•		
Legal Fees	Various		\$	121	_		\$		Out-of-Stat	te Travel	\$	
Legal Fees	Various		_	376			_					
Purchased Services	Various		_	80			_					
Purchased Services	Various		_	(949)			_		In-State Tr	avel		8,139
Purchased Services	Various		_	(146)			_					
Purchased Services	Various		_	1,251			_					
Consulting	Various	-	_	1,053			_					
Consulting	Various		_	1,985					Seminar Ex	pense		
Consulting	Various		_	9,773								
Consulting	Various		_	16,020								
Consulting	Various		_	52,888			_		Home Office	e Allocation		5,134
Consulting	Various		_	632			_			ent Expense		
TOTAL (agree to Schedule V, lir			_		TOTAL		\$			(agree to Sch.	v. •	-
/	ttach copy of invoice			83,084					TOTAL	line 24, col. 8)	,	13,273

^{*} Attach copy of IMRF notifications

^{**}See instructions.

STATE	OF	ILLI	NO	I	S

Page 22 12/31/03 Facility Name & ID Number Provena Geneva Care Center Report Period Beginning: Ending: 1/1/03 0043448

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

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TOTALS

	(See instructions.)				`		,	,					
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year Amount of Expense Amortized Per Year											
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
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			OF ILLINOIS				Page 23
	y Name & ID Number Provena Geneva Care Center	#	0043448	Report Period Beginning:	1/1/03	Ending:	12/31/03
	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union? No	(13)	the Department of	supplies and services which are of the Public Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. 5048 - Life Service Network	40	,	Yes Yes			C
(3)	Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy, explains how all related costs were al	day care, etc.	For exampl) If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 107	(15)	Indicate the cost of on Schedule V. related costs?			been offset ag	
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 7 years	(16)	Travel and Transp	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \qquad \qquad \qquad Line \qquad \qquad 10		If YES, attach a	complete explanation. eparate contract with the Department	t to provide m		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?		program during c. What percent of	this reporting period. \$ N/A all travel expense relates to transpor age logs been maintained? N/A			
(8)	Are you presently operating under a sale and leaseback arrangement: No N/A		e. Are all vehicles times when not	stored at the nursing home during the in use? N/A			
(9)	Are you presently operating under a sublease agreement? YES X NO	1	out of the cost re	commuting or other personal use of a eport? N/A ity transport residents to and fr	-		No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over	,	Indicate the a	mount of income earned from p n during this reporting period.	roviding suc	ch \$ <u>N/A</u>	
	N/A	(17)	Firm Name: K	performed by an independent certifie PMG	•	The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,583 This amount is to be recorded on line 42 of Schedule V.		been attached?	that a copy of this audit be included No If no, please explain.	not issued	yet	
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.	(18)	Have all costs whitout of Schedule V	ch do not relate to the provision of lo	ng term care l	been adjusted o	ou
	<u> </u>	(19)	performed been att	re in excess of \$2500, have legal invaled to this cost report? N/A d a summary of services for all archi		-	ices

Provena Geneva Care Center 0043448 Attachment for Related Facilities 12/31/2003

Related Nursing Homes

Facility Name City Provena Our Lady of Victory Bourbonnais Provena Pine View Care Center St. Charles Provena Geneva Care Center Geneva Provena Cor Mariae Center Rockford Provena St. Joseph Center Freeport Provena McAuley Manor Aurora Provena St. Anne Center Rockford Provena Villa Franciscan Joliet Provena Heritage Village Kankakee

Doloted Ducinosa Entitios

Related Business E		
Facility Name	<u>City</u>	<u>Notes</u>
Provena Clinics		Physician's Clinics
Provena Fortin Villa Learning C	Childrens Center	
Provena Fox Knoll	Aurora	Retirement Community
Provena Health	Frankfurt	Parent Company
Provena Home Care		Home Health
Provena Home Equipment		Home Equipment
Provena Hospice		Hospice
Provena Hospitals		Hospital
Provena Laverna Terrace	Avilla, IN	Independent Living
Provena Meadowview Lodge	Kankakee	Supportive Living
Provena Senior Services	Mokena	Management Company
Provena Senior Services Pharm	Pharmacy	
Provena St. Joseph Adult Day (Adult Day Care	
Provena St. Mary's Adult Day C	a Kankakee	Adult Day Care
Provena St. Vincent	Freeport	Community Living
St. Anne's Place	Rockford	Independent Living

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